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Sound Family Psychiatry

Billing Information and Financial Agreement

Client Name:_____ Phone: _____

If another person is responsible for payment:

Name: _____ Phone: _____

Address: _____ Relationship: _____

Statement of Financial Responsibility

- I agree to be financially responsible for all charges that accrue from consultation and treatment, including those not reimbursed by my health insurance.
- I agree to be financially responsible for appointments cancelled without 48 hours notice, or for no-shows to appointments, in accordance with the cancellation policy.
- In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding amount balances.
- This authorization will remain in effect indefinitely.

Payment Authorization

Payment is accepted in the form of cash, check or payment via IvyPay.

I understand that IvyPay is available for session payment, which is a HIPAA compliant payment program specific to mental health care. I agree to enroll in IvyPay for safe, secure payments for sessions as well as missed appointments, according to the cancellation policy for Sound Family Psychiatry.

Patient Signature: _____ Date: _____

Patient Representative Name: _____ Date: _____

Patient Representative Signature: _____ Relation to Patient: _____